West River Head Start

DENTAL EXAM / ORAL HEALTH FORM

Patient Information

Child's Name:	Child's DOB:	Date Exam / Screening Completed:

Current Oral Health Status

ORAL CONDITION	
Missing	☒
Decayed	⊜
Filled	●

UPPER

3 A B C D E F G H I J 14

Lingual

LEFT RIGHT

Lingual

30 T S R Q P O N M L K 19

LOWER

Number of times per day child brushes teeth: ______________

Gum Condition: ☐ Normal ☐ Swollen ☐ Bleeds Easily ☐ Infected

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needed

Oral Health Care Services Delivered During Visit

Diagnostic / Preventive Services

X-rays: Yes ☐ No ☐

Risk assessment: Yes ☐ No ☐

Cleaning: Yes ☐ No ☐

Fluoride varnish: Yes ☐ No ☐

Dental sealants: Yes ☐ No ☐

Counseling / Anticipatory Guidance

Yes ☐ No ☐

Referral to Specialty Care

Yes ☐ No ☐

____

(Please specify specialist)

Restorative / Emergency Care

Fillings: Yes ☐ No ☐

Crowns: Yes ☐ No ☐

Extractions: Yes ☐ No ☐

Emergency care: Yes ☐ No ☐

Other: _______________________

(Please specify)

Future Oral Health Care Services

All treatment completed: Yes ☐ No ☐

Next recall date: _______/_______ (month/year)

More appointments needed for treatment? Yes ☐ No ☐

If yes: Approximate number of appointments needed: _______

Next appointment: Date:_______ Time:_______

Additional Information for parent, head start staff, and medical providers:

Oral Health Provider's Contact Information and Signature

Provider Name (printed)	Phone Number	Fax Number
Provider Signature / Date	Address	

Please return form by fax to (701) 663-9643 or mail to:

West River Head Start 1004 7th Street SW Mandan, ND 58554 Tel (701) 663-9507	West River Head Start PO Box 197 Carson, ND 58529 Tel (701) 622-3505	West River Head Start PO Box 487 Hazen, ND 58545 Tel (701) 748-3736	West River Head Start PO Box 197 New Salem, ND 58563 Tel (701) 843-8061